DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/26/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445047	A. BUILDING _____ B. WING _____	07/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IMPERIAL GARDENS HEALTH AND REHABILITATION	306 W DUE WEST AVE MADISON, TN 37115

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS During the Recertification Survey conducted July 16 to 18, 2012, complaints TN30115 and TN30043 were investigated. No deficiencies were cited related to complaint TN30115 under 42 CFR PART 483.13, Requirements for Long Term Care.	F 000	This Plan of Correction (POC) has been developed in compliance with State and Federal Regulations. This Plan affirms Imperial Garden Health and Rehabilitation intent and allegation of compliance with those regulations. This POC does not constitute an admission or concession of either accuracy or factual allegation made in, or existence or scope of significance, of any cited deficiency.	
F 203 SS=D	483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section. Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged. Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days.	F 203	Completion 8/8/12	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 203	Continued From page 1 The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, and interview the facility failed to issue a written thirty day notice prior to discharge for two (#22, # 23) of twenty- four residents reviewed. The findings included: Resident # 22 was admitted to the facility on October 11, 2011, with diagnoses including Chronic Alcoholism, Diabetes, Coronary Artery Disease, and Hypertension. Medical record review of the quarterly Minimum Data Set dated April 3, 2012, revealed the	F 203		

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F 203	Continued From page 2 resident required no assistance with decision making, had no problem with memory, required supervision with transfers, and utilized an electric wheelchair for locomotion. Review of a Physician's Progress note dated March 30, 2012, revealed, "I was asked to see... (resident) today following a protracted episode which has been ongoing for past 12-18 hours... (Resident) has left the building on several occasions and returned last night, smelling of alcohol and was obviously intoxicated...At this time, his medications are to be held...(Resident) will be given a 30-day notice to find another place to live..." Review of Social Service Notes dated April 24, 2012, revealed the resident was informed of the need to complete a new Pre-Admission Evaluation (PAE) (Criteria which determines a resident's eligibility for long term care services) and the possibility of the resident being denied long term care services secondary to the resident's high functioning. Review of a letter dated May 14, 2012, from the Department of Finance and Administration Bureau of Tenncare, revealed, "...the PAE the application for Medicaid to pay had been denied... (Resident) has the right to appeal this denial... If... (resident) appeals, it must be done within 30 days..." Interview with the Social Service Director on July 18, 2012, at 9:30 a.m., in the Social Service Office, revealed the resident refused to talk with Social Service regarding the PAE appeal. The resident would only talk with the former Director	F 203	**F203** **1. Resident #22 was mailed a copy of a 30 day discharge letter by the administrator on 7/30/12.** **Resident #23 was mailed a copy of a 30 Day discharge letter by the administrator On 7/30/12.** **2. A 100% audit was done by administrator on all discharged/transferred residents for the last month. No other residents were identified to be affected.** **3. The Transfers and Discharge Policy was revised to ensure that it complied with all regulations/guidelines. The social worker and administrator were inserviced on 7/19/12 by the regional quality improvement coordinator on the regulation for notice requirements before discharge/transfer. New hires will be inserviced in orientation.**	

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F 203	Continued From page 3 of Nursing. Continued interview revealed there was no documentation the facility had applied for an appeal of the PAE. Medical record review of a Nursing Note dated June 24, 2012, revealed, "Resident was noticed (noted) to be leaning in the electric w/c (wheelchair)... Temp (temperature) was 102.4. Resident seemed disoriented. Speech was slurred, movement unsteady and shaky. Transferred to...(local hospital) ER (Emergency Room)..." Medical record review of a Physician's Order dated June 24, 2012 revealed, " Transfer to... (local hospital) for evaluation and treatment for elevated temperature and slurred speech." Interview with the Administrator on July 18, 2012, at 10:00 a.m., in the Administrator Office, confirmed the facility refused to re-admit the resident to the facility on July 2, 2012, for past behaviors. Continued interview confirmed the facility failed to issue a thirty day discharge notice prior to the discharge. Resident #23 was admitted to the facility on October 14, 2011, with diagnoses including Advanced Cirrhosis of the Liver, Bipolar Mood Disorder, Diabetes, Seizures, and Alcohol Abuse. Medical record review of the quarterly Minimum Data Set dated April 3, 2012, revealed the resident required no assistance with decision making, had no problem with memory, and required supervision with transfers.	F 203	4. The administrator will audit all discharge/transfers For proper notice weekly x 4 weeks, than monthly for 2 months and/or 100% compliance. The results will be reported to the Quality Assurance Performance Improvement Committee comprised of Medical Director, Director of Nursing, Administrator, Assistant Director of Nursing, Minimum Data Set Coordinator, Dietary Manager, Activities Director, Social Services, Maintenance Supervisor, and Environmental Director.	8/8/12

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F 203	Continued From page 4 Review of the facility's documentation dated June 15, 2012, at 11:24 p.m., revealed, "...Resident #1 had hit the roommate, who will be known as resident #2, came to the nursing station holding...right upper arm and said, "I am scared of...(resident #23)...(resident) hit me...small red area noted on upper arm...Physic (Psych/Mental hospital) hospital for evaluation and treatment..." Review of a Physician's Progress note dated June 15, 2012, revealed, "PLAN: Patient will have to be involuntary committed to a psych unit. He is a high risk to staff and other residents and cannot be in the facility." Review of the facility's Involuntary Transfer and Discharge Policy revealed no documentation on giving a written thirty day discharge notice to the resident or responsible party prior to discharge. Medical record review revealed the resident was admitted to the Mental Health Facility on June 15, 2012. Interview with the resident's mother on July 19, 2012, at 1:00 p.m., by phone, revealed the resident remains in the Mental Health Facility. Interview with the Social Service Director on July 17, 2012, at 2:00 p.m., in the Chapel, confirmed the hospital was notified on June 25, 2012, that the facility would not re-admit the resident related to the behaviors. Interview with the Administrator on June 17, 2012, at 3:00 p.m., in the conference room, confirmed neither the resident, or the power of attorney, were given a written thirty day	F 203		

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F 203	Continued From page 5 discharge notice prior to the transfer to an acute care facility. C/O # 30043	F 203		
F 205 SS=D	483.12(b)(1)&(2) NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies the duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility, and the nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, and interview the facility failed to issue a written notice of the bed hold policy prior to the transfer to an acute care facility for one (# 23) of twenty-four residents reviewed. The findings included:	F 205		

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F 205	Continued From page 6 Resident #23 was admitted to the facility on October 14, 2011, with diagnoses including Advanced Cirrhosis of the Liver, Bipolar Mood Disorder, Diabetes, Seizures, and Alcohol Abuse. Medical record review of the quarterly Minimum Data Set dated April 3, 2012, revealed the resident required no assistance with decision making, had no problem with memory, and required supervision with transfers. Review of the facility's documentation dated June 15, 2012, at 11:24 p.m., revealed, "...Resident #1 had hit the roommate, who will be known as resident #2, came to the nursing station holding...right upper arm and said, "I am scared of...(resident #23)...(resident) hit me...small red area noted on upper arm...Physic (Psych/Mental hospital) hospital for evaluation and treatment..." Review of a Physician's Progress note dated June 15, 2012, revealed, "PLAN: Patient will have to be involuntary committed to a psych unit. He is a high risk to staff and other residents and cannot be in the facility." Medical record review revealed the resident was admitted to the Mental Health Facility on June 15, 2012. Review of the facility's Bed Hold and Readmission Policy revealed, "...Private pay residents: Full rates are charged from the first day of absence. The resident and / or responsible party will be charged at 100% of the current room pay rate to reserve the bed...Medicaid Intermedicare Residents: The Medicaid program will cover the first 10 days if the resident is placed	F 205	F205 1. Resident #23 was mailed a copy of the Bed-Hold Policy by social services on 7/30/12. 2. A 100 % audit was done on all residents transferred in the last month by social services on 7/19/12. No other resident were identified has being affected. 3. The social worker was inserviced by the administrator on 7/19/12 on the notice of Bed-Hold Policy Before/Upon Transfer. The licensed nursing were inserviced by the nurse educator 7/18/12 - 8/3/12 on sending bed hold policy with resident at time of transfer. All new hires will be inserviced in orientation.	

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F 205	Continued From page 7 in a hospital or goes on a therapeutic leave. In accordance with current state policy, after the 10th day, the resident and / or responsible party may hold the bed by paying 100% of the current room rate for that particular bed..." Interview with the Social Service Director on July 17, 2012, at 2:00 p.m., in the Chapel, confirmed the hospital was notified on June 25, 2012, that the facility would not re-admit the resident related to the behaviors. Interview with the Administrator on June 17, 2012, at 3:00 p.m., in the conference room, confirmed neither the resident, or the power of attorney, were given a written notice of the bed hold policy prior to the transfer to an acute care facility. C'O # 30043	F 205	**4. The Social Worker will audit transfers on a daily basis to ensure compliance to the Bed Hold policy is achieved and maintained. The results will be reported by the Social Worker to the QA /PI Committee which is comprised of the Medical Director, Administrator, Director of Nursing, MDS Coordinator, Dietary Manager, Activities Director, Plant Operations Manager, Environmental Services Manager, and Administrator. 8/21/12** 8/21/12	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, the facility failed to maintain call lights within reach, and answer resident calls for assistance promptly, for two residents,(#4, #15,)	F 246		

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F 246	Continued From page 8 of twenty- four residents reviewed. The findings included: Resident #4 was admitted to facility on July 17, 2010, with diagnoses including, Unspecified Cerebral Artery Occlusion, Hypertension, Type 2 Non-Insulin Dependent Diabetes, and Altered Mental Status. Observation of the resident on July 16, 2012, from 4:08 p.m., to 4:49 p.m., from the 400 hallway corridor revealed, the resident supine on the bed in room 410, calling out "hey, hey" in a raised voice beginning at 4:08 p.m. Three facility staff including one Licensed Practical Nurse, and two Certified Nursing Assistants (CNA) were observed on the 400 hallway. Continued observation from 4:08 p.m., to 4:25 p.m., on the 400 hallway revealed, the resident continued to call out "hey, hey" in a raised voice. Continued observation at 4:26 p.m., on the 400 hallway, revealed, Certified Nursing Assistant (CNA #5) answered a call light in Room 401, (across the hallway from resident #4) and exit the room, proceed down the hallway and left around the corner to the adjacent unit at 4:27 pm. Continued observation from 4:27 p.m., to 4:35 p.m. revealed resident #4 calling out continuously "hey hey" in a raised voice. At 4:35 p.m. the LPN left the med cart, and summoned a CNA from the activity room adjacent to the unit, to the unit to assist with care. Continued observation at 4:37 p.m., revealed the	F 246	**F246** **1. Resident # 4 condition was assessed by the Assistant Director of Nursing, Administrator, and Social Services on 7/18/12. The Assistant Director of Nursing notified the physician and no new orders.** **No adverse outcomes noted.** **Resident #15 Call light was placed within reach on 7/16/12 by Certified Nursing Assistant. Certified Nursing Assistant placed tray within reach on 7/16/12. Housekeeping cleaned the room on 7/16/12.** **2. A 100% room audit was done on 7/17/12 by central supply to ensure that all call lights were within reach. No other residents were affected.**	

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F 246	Continued From page 9 CNA summoned to the unit by the nurse proceeded from the activity room to room 401 and entered room 401 as resident #4 continued calling out more loudly from room 410. Continued observation at 4:41 p.m. revealed a central supply technician entered the unit, entered room 410, attempted to communicate with the resident, and exited the room at 4:42 p.m., then proceed to the medication cart and spoke with the licensed practical nurse and exited the unit at 4:43 p.m. Continued observation revealed resident #4 calling out from room 410 in a raised voice from 4:43 p.m. to 4:48 p.m. Continued observation revealed CNA #5 entered the unit from the adjacent 300 hallway and proceeded to resident #4's room, entered the room, and closed the door at 4:49 p.m. CNA #5 exited the room at 4:56 p.m. Interview with CNA #5, on July 16, 2012, at 4:58 p.m. on the 400 hall outside the resident's room revealed, resident #4 was incontinent of urine. Continued interview confirmed the forty one minute delay in responding the resident's calls for assistance, resulted in the resident's needs not being met. Interview with the facility Administrator and the Regional Vice President of Clinical Services on July 17, 2012, at 2:20 p.m., in the Administrator's office, confirmed the forty-one minute delay observed was excessive and the resident's needs were not met.	F 246	3. All employees (nursing, dietary, therapy services, Housekeeping, social services, activities and administration) were inserviced by the Nurse Educator on maintaining call lights in reach and answering in a timely manner, and responding to residents that voice assistance starting 7/19/12 - 8/3/12. All new hires will be inserviced in orientation.	

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F 246	Continued From page 10 Resident #15 was admitted to the facility on October 19, 2005, with diagnoses including Cerberal Artherosclerosis, Diabetes Mellitus, Hypertension, Encephalopathy, and Heart Failure. Medical record review of the Minimum Data Set dated June 29, 2012, revealed the resident had severely impaired memory and cognition and required extensive assistance with Activities of Daily Living (ADLs). Observation of the resident on July 16, 2012, at 1:45 p.m., revealed the resident sitting up in a wheelchair in the resident's room. Further observation revealed the resident's bedside table was pushed away from the resident so that the tray was out of arm's reach of the resident. Further observation revealed a bowl of crackers spilled on the floor next to the bedside table and the resident was heard to be calling out from the room. Continued observation revealed no evidence of a call light within sight or reach of the resident. Observation and interview in the resident's room on July 16, 2012, at 2:00 p.m., with Certified Nursing Assistant (CNA) # 1 and Licensed Practical Nurse (LPN) #1, revealed the resident was sitting in a wheelchair with the call light hanging on the privacy curtain in the resident's room. Continued observation revealed the privacy curtain was located behind, to the right and out of reach of the resident. Continued observation and interview with CNA #1 and LPN #1, confirmed the resident was unable to locate and use the call light, and confirmed the resident was unable to call for assistance from the staff	F 246	4. The Nurse Educator and/or Administrator will do an Audit on 30 residents for call lights being within reach And Call lights answered in a timely manner bi-weekly x 4 weeks, then weekly x 4 weeks and/or 100% compliance. The Nurse Educator will report the results to the Quality Assurance Performance Improvement Committee comprised of Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Minimum Data Set Coordinator, Dietary Manager, Social Services, Activities, Maintenance Supervisor, and Environmental Director.	8/8/12

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IMPERIAL GARDENS HEALTH AND REHABILITATION	306 W DUE WEST AVE MADISON, TN 37115

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 246	Continued From page 11 due to call light being out of visual sight and reach of the resident.	F 246		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview the facility failed to follow Physician's Orders for obtaining lab work as ordered for one resident (#9) of twenty-four residents reviewed. The findings included: Resident #9 was admitted to the facility on April 17, 2008, with diagnoses including Depressive Disorder, Late-effect Hemiplegia, Hypertension and Vascular Dementia. Medical record review of the Physician's Orders signed July 12, 2012, revealed, "Lab: Basic Metabolic Panel (BMP)/Complete Blood Count q (every) 3 months 3rd Fri (Friday) April July October January lab start date: 09/24/2008". Continued review of the Physician's Orders revealed: "Lab: Liver Function Test (LFT)/Lipid Panel q 6 months 3rd Fri April October lab start date: 09/24/2008". Medical record review of lab reports revealed no documentation of labwork completed for the month of April. Interview on July 17, 2012, at 2:20 p.m., at the	F 281	F281 1. The Assistant Director of Nursing Notified the physician on lab for Resident #9 on 7/17/12. New orders obtained. Resident Assessed by Assistant Director of Nursing On 7/17/12. No adverse outcome noted. 2. A 100% audit of lab work orders for the last 30 days will be completed by the Nurse Supervisor 7/19/12 – 8/3/12. 3. All licensed nurses will be inserviced by the Nurse Educator 7/18/12 - 8/3/12 on following physicians orders for lab. All new hires will be inserviced in orientation.	

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F 281	Continued From page 12 200 Hall nurse station with Assistant Director of Nursing (ADON), confirmed the facility failed to obtain any labwork for the resident in the month of April as ordered by the physician.	F 281	4. The Assistant Director of Nursing and/or Nursing Supervisor will audit 20 labs weekly x 4 weeks, then monthly x 2 months and/or until 100% compliance. The Assistant Director of Nursing will report the results to the Quality Assurance Performance Improvement Committee comprised of Medical Director, Administrator, Director of Nursing, Assistant Director Nursing, Minimum Data Set Coordinator, Dietary Manager, Activities, Social Services, Maintenance Supervisor, and Environmental Director.	8/8/12
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility documentation review, observations, and interview, the facility failed to plan and implement interventions to prevent accidents for two (#10, #21) of twenty-four residents reviewed. The findings included: Medical record review revealed Resident #10 was admitted to the facility on February 12, 2012, with diagnoses of: Brain Condition (Dementia) Coronary Artery Disease, Hypertension, Chronic Pulmonary Disease, and Peripheral Vascular Disease. Review of the resident's Minimum Data Set (MDS, an assessment form) dated May 25, 2012, revealed the resident scored a "5" (out of a possible 15, a score of 5 indicates impaired cognitive ability) on the Brief Interview for Mental	F 323		

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F 323	Continued From page 13 Status (BIMS). Further review of the MDS revealed the resident required extensive assistance of two or more people for transfers. Review of facility documentation, dated May 12, 2012, revealed Resident #10, "Observed on Floor", on May 12, 2012, at 2:30 p.m. Further document review revealed the facility's intervention was, "continue to observe". Review of facility documentation, dated June 30, 2012, revealed Resident #10, had, "Fall observed on Floor", on June 30, 2012, at 11:00 a.m., without injury. Further document review revealed the facility's intervention was, "continue to observe". Review of facility documentation, dated July 7, 2012, revealed Resident #10, had a, "Fall observed on Floor", on July 7, 2012, at 10:45 p.m., without injury. Further document review revealed the facility's intervention was, "continue to observe". Review of facility documentation, dated July 8, 2012, revealed Resident #10, was "Observed on Floor", on July 8, 2012, at 3:41 a.m., with no apparent injury. Further review revealed the facility's intervention was, "continue to observe". Observation on July 17, 2012, at 7:25 a.m. revealed Resident #10, sitting in a wheelchair near nursing station. Resident is awake and alert but unresponsive to questions. Interview with the Assistant Director of Nursing (ADON) on July 17, 2012, at 8:45 a.m. confirmed Resident #10 had fallen on May 12, June 30, July	F 323	F323 1. **On 7/10/12 resident #10 was screened by physical therapy. On 7/13/12 merry walker was discontinued and resident was recommended for placement in wheelchair. Resident had no more falls after placement in wheelchair.** **On 7/18/12 resident #21 had floor mat on right side of bed removed and non-slip strips were applied to floor on right side of resident's bed. Resident was also placed on a night time toileting program.** 8/8/12 2. **The QA/PI Committee will evaluate all residents for their fall risk by 8/24/12. Actual falls will be evaluated on a daily basis by the Clinical Leadership Team to ensure policy is adhered to and proper interventions are in place to reduce the risk of future falls.** 8/31/12	

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F 323	Continued From page 14 7, and July 8, 2012 (all no injury falls), with no new interventions implemented to prevent falls. Resident #21 was admitted to the facility on November 11, 2006, with diagnosis of: Closed Fracture of Carpal Bone, Ulcer of Calf, Essential Hypertension (high blood pressure), Senile Dementia, Acute Delusions, and Decubitis Ulcer. Medical record review of the Minimum Data Set dated December 31, 2011, and June 24, 2012, revealed the resident had a severely impaired cognition, required supervision for transfers and ambulation, and had a history of falls. Medical record review of a Nurse's Note dated April 18, 2012, revealed the resident had a" ... fall with no injury, interventions initiated : bed alarm to bed, teaching done: unable to teach resident R/T (related to) dementia ...". Further review of a Nurse's Note dated April 20, 2012, revealed a "... fall with a minor skin tear, no new interventions, instructed resident on safe transfer techniques use of call light ...". Additional medical record review of a Nurse's Note dated May 5, 2012, revealed "...fall with skin tears, no new interventions , instructed resident on use of call light...". Review of a Nurse's Note dated July 14, 2012, revealed an additional "... fall with no injury, no new interventions, teaching done: use of call light ...". Observation of the resident on July 17, 2012, at	F 323	**3. The Nurse Educator will inservice all nursing personnel on reducing fall risk and implementing appropriate interventions to reduce the risk of falls. This will be completed by 8/31/12.** 8/31/12 **4. The Assistant Director of Nursing and/or Administrator will audit all falls 5 x a week X 3 months and/or 100% compliance for appropriate intervention. The Assistant Director of Nursing will report the results to the Quality Assurance Performance Improvement Committee comprised of Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Minimum Date Set Coordinator, Dietary Manager, Activities, Social Services, Maintenance Supervisor, and Environmental Director.** 8/8/12	

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F 323	Continued From page 15 2:16 p.m., in the resident's room revealed the resident was in bed oriented to place and person, the bed was in the low position, a bed pad alarm was in place and functioning, fall mats were in place on both sides of the bed, and there was a four point cane in the corner of the room. Interview with the Assistant Director of Nursing (ADON) on July 18, 2012, at 11:30 a.m., in the chapel, confirmed that the facility had failed to initiate new interventions after resident falls.	F 323		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, review of manufacturer's specifications, and interview, the facility failed to prevent medication errors less than five percent resulting in three errors in fifty opportunities to equal an error rate of six percent. Observations revealed errors occurred with one (Licensed Practical Nurse [LPN] #1) of eight nurses, on two (Center Split, East Split) of six medication carts, on one (7 a.m., to 7 p.m.) shift of two shifts, and on three (Resident A, Resident B, Resident C) of thirteen residents observed. The findings included: Mediation Error #1	F 332	F332 1. Resident "A" was assessed on 7/16/12 by the Assistant Director of Nursing. No adverse Outcomes noted. The physician was notified by the Assistant Director of Nursing on 7/16/12. No new orders noted. The LPN # 1 was inserviced by the Nurse Educator on the proper administration of insulin on 7/16/12.	

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F 332	Continued From page 16 Observation on July 16, 2012, at 10:55 a.m., at the Center Split Cart, revealed LPN #1 administered a 4 unit dose of Humulin R Injectable Insulin 100 units per milliliter (ml) for Diabetes subcutaneously (under the skin) in the left upper abdomen of Resident A. Resident A had a recorded blood glucose level of 235. Further observation on July 16, 2012, at 11:54 a.m., in the Main Dining Room, with the Restorative Technician #1, revealed lunch was served to Resident A fifty-nine minutes after the administration of Humulin R Insulin. Medical record review of the July 2012, Recapitulation orders for Resident A revealed an order for "...HumuLIN R 100 UNIT/ML Solution Injection sub-Q [subcutaneously]...per sliding scale...1130 [11:30 a.m.]...Sliding Scale...201-250 [blood glucose level] = 4 units..." Review of the manufacturer's specifications for the short acting Humulin R Insulin revealed, "...The injection of Humulin R U-100 should be followed by a meal within approximately 30 minutes of administration..." Interview with Restorative Technician #1, on July 16, 2012, at 11:54 a.m., in the Main Dining Room, confirmed lunch was served to Resident A at 11:54 a.m. Interview with LPN #1 on July 16, 2012, at 5:20 p.m., at the Center Split Hall Cart, in the Center Hall, confirmed the dose of Humulin R insulin was administered on July 16, 2012, at 10:55 a.m., to Resident A, and LPN #1 "was not aware of	F 332	Resident "B" was assessed on 7/16/12 by the Assistant Director of Nursing. No adverse Outcomes noted. The physician was notified by the Assistant Director of Nursing on 7/16/12. No new orders noted. Resident "C" was assessed on 7/16/12 by the Assistant Director of Nursing. No adverse Outcomes noted. The physician was notified by the Assistant Director Of Nursing on 7/16/12. No new orders noted.	

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F 332	Continued From page 17 manufacturer's specifications" for administering Humulin R Insulin. Humulin R Insulin was administered to Resident A fifty-nine minutes before a meal (lunch) and not 30 minutes before a meal per manufacturer's specifications. Medication Error #2 Observation on July 16, 2012, at 11:15 a.m., at the East Split Cart, revealed LPN #1 administered a 14 unit dose of Humalog Injectable Insulin 100 units per ml for Diabetes subcutaneously in the left lower abdomen of Resident B. Further observation on July 16, 2012, at 11:47 a.m., in the Main Dining Room, with Restorative Technician #1, revealed lunch was served to Resident B thirty-two minutes after the Humalog Insulin dose was administered. Medical record review of the signed physician order, dated July 10, 2012, for Resident B, revealed an order for "...Humalog 14 units SQ [subcutaneously] at 11:30 [a.m.]..." Review of the manufacturer's specifications for Humalog Insulin revealed, "...HUMALOG® is a rapid acting human insulin analog indicated to improve glycemic control in adults...Administer within 15 minutes before a meal or immediately after a meal..." Interview with Restorative Technician #1, on July 16, 2012, at 11:47 a.m., in the Main Dining Room, confirmed lunch was served to Resident B at 11:47 a.m. Interview with LPN #1 on July 16, 2012, at 5:20	F 332	2. The Nurse Educator began med Pass observation and inservice on Proper administration of insulin for licensed Nursing staff on 7/16/12. 3. All licensed nursing will be inserviced by the Nurse Educator on the proper administration of insulin 7/16/12 - 8/3/12. All new hires will be inseviced in orientation.	

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F 332	Continued From page 18 p.m., at the Center Split Hall Cart, in the Center Hall, confirmed the dose of Humalog insulin was administered on July 16, 2012, at 11:15 a.m., to Resident B, and LPN #1 "was not aware of manufacturer's specifications" for administering Humalog Insulin. Humalog Insulin was administered to Resident B thirty-two minutes before a meal and not within 15 minutes before a meal or immediately after a meal per manufacturer's specifications. Medication Error #3 Observation on July 16, 2012, at 11:25 a.m., at the Center Split Cart, revealed LPN #1 administered a 2 unit dose of Novolog Injectable Insulin 100 units per ml for Diabetes in the left lower abdomen of Resident C. Resident C had a recorded blood glucose level of 163. Further observation on July 16, 2012, at 11:52 a.m., in the Main Dining Room, with Restorative Technician #1, revealed lunch was served to Resident C twenty-seven minutes after the Novolog Insulin dose. Medical record review of the July 2012, Recapitulation orders for Resident C, revealed an order for "...NovoLOG 100 UNIT/ML Solution sub-Q per sliding scale...151-200 = 2 units..." Review of the manufacturer's specifications for Novolog Insulin, revealed "...eat a meal within 5 to 10 minutes after using NovoLog® to avoid low blood sugar...NovoLog® is a fast-acting insulin..." Interview with Restorative Technician #1 on July 16, 2012, at 11:52 a.m., in the Main Dining Room,	F 332	4. The Assistant Director of Nursing and/or Nurse Educator will do an audit/observe the administration Of insulin on 10 residents per week x 4 weeks, then 10 residents monthly for 2 months and/or 100% compliance. The Nurse Educator will report the results to the Quality Assurance Performance Improvement Committee comprised of Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Minimum Data Set Coordinator, Dietary Manger, Activities, Social Services, Maintenance Supervisor, and Environmental Director.	8/8/12

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F 332	Continued From page 19 confirmed lunch was served to Resident C at 11:52 a.m. Interview with LPN #1 on July 16, 2012, at 5:20 p.m., at the Center Split Hall Cart, in the Center Hall, confirmed the dose of Novolog insulin was administered on July 16, 2012, at 11:25 a.m., to Resident C, and LPN #1 "was not aware of manufacturer's specifications" for administering Novolog Insulin. Novolog Insulin was administered to Resident C twenty-seven minutes before a meal and not within 5 to 10 minutes before a meal per manufacturer's specifications.	F 332	F369 1. Resident # 3 received a divided plate on 7/17/12 for lunch by dietary manager. Resident # 3 was assessed by the Assistant Director of Nursing on 7/17/12. No adverse Outcomes noted. The physician was Notified by the Assistant Director of Nursing on 7/17/12. No new orders noted. Dietary manager was inserviced by the Administrator on 7/17/12 to ensure Assistive devices in place. 2. A 100% audit was done on residents with orders for assistive devices by the Dietary Manager on 7/17/12. No other resident Identified to be affected.	
F 369 SS=D	483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS The facility must provide special eating equipment and utensils for residents who need them. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and interviews the facility failed to provide adaptive eating equipment required for one resident (#3) of twenty-four residents reviewed. The findings included: Medical Record review revealed Resident #3 was admitted to the facility on June 7, 2011, with diagnoses of Pnuemonia, Coronary Artherosclerosis, Alzheimers Disease, and Pressure Ulcers. Review of the Care Plan dated March 28, 2012, revealed Resident #3 was identified having a potential for unintended weight loss and had a	F 369		

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F 369	Continued From page 20 "Divided Plate for Meals" planned as an intervention. Observation of Resident #3 in the dining room on July 17, 2012, at 7:35 a.m. revealed the resident feeding self from a regular flat plate (not the divided plate listed on the care plan). Observations of the resident tray revealed a meal card which stated, "Divided Plate". Interview with Certified Nursing Assistant (CNA) #4, in the resident dining room, at 7:35 a.m., on July 17, 2012, confirmed Resident #3 did not have a divided plate. Interview with the Dietary Manager on July 17, 2012, at 7:45 a.m., in the resident dining room, confirmed Resident #3 did not have a divided plate. Further interview with the Dietary Manager confirmed the resident was to have meals served on a divided plate.	F 369	3. The dietary staff were inserviced by the Dietary Manager on following orders for assistive devices 7/17/12 - 8/3/12. All new hires will be inservice in orientation. 4. The Dietary manager will audit the residents with orders for assistive devices weekly x 4 weeks, then monthly x 2 months and/or 100% compliance. The results will be reported by the Dietary Manager to the Quality Assurance Performance Improvement Committee comprised of Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Minimum Date Set Coordinator, Activities, Social Services, Maintenance Supervisor, Dietary Manager, and Environmental Director.	8/8/12
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility;	F 441		

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F 441	Continued From page 21 (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review, and interview, the facility failed to provide a safe and sanitary environment to help prevent the development and transmission of disease and infection for one (Licensed Practical Nurse [LPN] #1) of six nurses, and three (Resident A, Resident B, Resident C) of thirteen residents observed, on one (7 a.m., to 7 p.m.) of two medication passes observed, and failed to properly handle linens for the prevention of the	F 441	F 441 1. Resident "A" was assessed on 7/16/12 by the Assistant Director of Nursing. No adverse Outcomes noted. The physician was notified by The Assistant Director of Nursing on 7/16/12. No new orders noted. The LPN # 1 was inserviced by the Nurse Educator on 7/16/12 regarding cleaning/disinfecting of glucometer and insulin administration.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445047	A. BUILDING _____ B. WING _____	07/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IMPERIAL GARDENS HEALTH AND REHABILITATION	306 W DUE WEST AVE MADISON, TN 37115

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 22 spread of infection for one resident (#5) of twenty-four residents reviewed. The findings included: Resident A was admitted to the facility on April 26, 2011, with diagnoses including Gastrointestinal Hemorrhage, Chronic Kidney Disease, Diabetes, Hypertension, and Depression. Observation on July 16, 2012, at 10:50 a.m., at the Center Split Cart, revealed LPN #1 cleaned the glucometer for blood glucose testing for Resident A. Further observation revealed LPN #1 used a 70% Alcohol pad for cleaning. Resident B was admitted to the facility on August 6, 2010, with diagnoses including Osteomyelitis, Altered Mental Status, Diabetes, Hypertension, and Congestive Heart Failure. Observation on July 16, 2012, at 11:10 a.m., at the East Split Cart, revealed LPN #1 cleaned the glucometer for blood glucose testing for Resident B. Further observation revealed LPN #1 used a 70% Alcohol pad for cleaning. Resident C was admitted to the facility on August 1, 2008, with diagnoses including Senile Dementia, Depressive Disorder, and Diabetes. Observation on July 16, 2012, at 11:20 a.m., at the Center Split Cart, revealed LPN #1 cleaned the glucometer for blood glucose testing for Resident C. Further observation revealed LPN #1 used a 70% Alcohol pad for cleaning.	F 441	**Resident "B" was assessed on 7/16/12 by the Assistant Director of Nursing. No adverse Outcomes noted. The physician was notified By the Assistant Director of Nursing on 7/16/12. No new orders.** **Resident "C" was assessed on 7/16/12 by the Assistant Director of Nursing. No adverse Outcomes noted. The physician was notified By the Assistant Director of Nursing on 7/16/12. No new orders.** **The linen in Resident # 5 bathroom was picked up and placed in dirty laundry hamper by the Certified Nursing Assistant on 7/16/12.**	

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F 441	Continued From page 23 Review of the facility policy, " Presto-Pro Blood Glucose Meter", revealed "The...blood glucose meter (glucometer) is cleaned and disinfected between each resident test [for blood glucose level]...Clean the glucometer with one Super Sani-Cloth [germicidal] Wipe and discard into the trash..." Interview with LPN #1 on July 16, 2012, at 10:52 a.m., at the Center Split Cart, confirmed LPN #1 "only used Alcohol wipes to clean glucometers." When asked if LPN #1 ever used germicidal wipes to clean glucometers, LPN responded, "No." Interview with the Assistant Director of Nursing (ADON) on July 16, 2012, at 1:45 p.m., in the ADON office, confirmed glucometers were to be cleaned only with Super Sani-Cloth Wipes (not Alcohol 70% pads) per facility policy. Resident #5 was admitted to the facility on August 4, 2011, with diagnoses including Closed Fracture, Difficulty Walking, Hypothyroidism, Bipolar Disorder and Insomnia. Observation on July 16, 2012, at 3:15 p.m., in the resident's bathroom, revealed several sheets piled on the floor next to the resident's toilet soaked in a yellow liquid which smelled of urine. Interview on July 16, 2012, at 3:15 p.m., in the resident's bathroom with Certified Nursing Assistant (CNA) #3, confirmed the sheets were not to be left on the bathroom floor, were to be placed in a plastic bag, and were not handled in a sanitary manner to prevent the spread of	F 441	**2. The Nurse Educator began med pass observation Inservice for licensed nursing staff on 7/16/12.** **A 100 % audit of resident's rooms was completed By central supply supervisor on 7/18/12 to ensure that no linen was on the floor. No other rooms identified has being affected.** **3. All licensed staff were inserviced by the nurse educator 7/16/12 - 8/3/12 on cleaning/disinfecting the glucometer. All staff (nursing, dietary, maintenance, housekeeping, therapy, activities, social services and administration) were inserviced by the nurse educator 7/18/12 - 8/3/12 on infection control, prevent spread, and proper handling of linen. All new hires will be inserviced in orientation.**	

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F 441	Continued From page 24 infection.	F 441	4. The Assistant Director of Nursing and/or the Nurse Educator will audit/observe the administration Of insulin on 10 residents per week x 4 weeks, then 10 residents monthly for 2 months and/or 100% compliance. The Administrator and/or Central Supply Director will audit 25 residents Rooms and bathrooms for proper handling Of dirty linen weekly x 4 weeks, then monthly X 2 months and/or 100% compliance. The Nurse Educator will report the Results of the audit on administration of insulin and the Administrator will report the results of the Audit on residents rooms and bathrooms for proper Handling of dirty linen to the Quality Assurance Performance Improvement Committee comprised of Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Minimum Data Set Coordinator, Dietary Manager, Activities, Social Services, Maintenance Supervisor, and Environmental Director.	8/8/12